

POLICY OPTIONS

Tailored health care for chronic disease in primary care: minimising the risks and maximising the benefits

An application of policy simulation

January 2012

B Pekarsky, T Lawson, C Mathews, P Yerrell, M Leach, P Clifton

Policy context

The policy that was the impetus for this project is the proposed Diabetes Coordinated Care Initiative (DCCI), the implementation of which was delayed pending the results of a DCC Pilot (DCCP). The DCC policy and pilot are intended to improve care for patients whose outcomes, as a group, are suboptimal under current mainstream primary care financing (MBS), and where the identified drivers of these suboptimal outcomes are:

- > the MBS financing structure provides incentives to treat the presenting problem rather than manage the chronic condition;
- > poor access to patient self-management education;
- > poor access to allied health professionals; and
- > limited availability of IT and clinical and care decision support software (CDSS).

At the time this research commenced, it was assumed, reasonably, that there would be sufficient information about specific policy parameters (e.g. the capitation rates) and policy mechanisms (e.g. the type of CDSS) to populate a policy simulation model that would allow the impact, risks and benefits of the policy to be explored under a range of scenarios. These scenarios would be defined by various combinations of patients, GPs and care settings.

However, there is very limited public domain information available on the DCC initiative; only the capitation rate, predicted uptake and total costs are available. In the absence of specific policy parameters, and given the Department's (Department of Health and Aging) interest in applying this approach to additional chronic conditions, a generic policy was characterised. This generic policy or scheme is "Tailored Health Care" (THC), where care for a cohort of patients is provided outside the MBS. THC is an institutional response to the complexity of managing patients with specific needs within a universal health care system such as the MBS.

THC solutions to care for distinct patient cohorts in Australian primary health care are not novel. Examples include: workplace and motor vehicle accident schemes and Veterans Schemes. Other models integrate MBS financing with other financing sources to provide care to cohorts of patients that can be defined as a "patient community". Examples include migrant health centres, HIV primary care clinics and Indigenous Health Services.

All THCs involve providers facing different sets of financial incentives compared to MBS, with the expectation that the care provided to these patients will be more likely to be effective (and more efficient to finance). The factors that differentiate the DCC from existing THCs are: that it is condition not cause-of-injury based; part of mainstream not non-mainstream general practice; and

eligibility is based on condition, not high risk of hospitalisation (as in the First and Second Round of the Coordinated Care Trials) or entitlement (as in DVA). Additionally, performance based payments are proposed.

RESEARCH QUESTIONS

The first research question is methodological:

- > How can a policy simulation be used to inform any THC style initiative, prospectively?

The second research question is intended to provide specific recommendations around risk management strategies for implementation of a THC style initiative.

- > What are the critical elements of an overarching policy framework for THC initiatives for Chronic Disease Management (CDM)?

Policy options – risk management strategies

The policy simulation identified five main sources of structural uncertainty – “known unknowns” – that were not part of the policy narrative and hence not explicitly considered in policy design. These sources of uncertainty mattered; patients’ decisions to enrol and their CtB from enrolment were expected to be sensitive to these parameters’ values. The risk management strategies associated with these parameters are the critical elements of an overarching regulatory policy.

Enhanced consent process:

Consent by a patient to enrol in a DCCI should be informed by an objective assessment of their CtB from enrolment. It is assumed that patients will be assessed at enrolment in order to classify them for capitation purposes (e.g. complex, recently diagnosed). This assessment does not inform the patient of their CtB from enrolment, only the expected services and costs of care. To inform a patient of their CtB, additional assessments are necessary. A pre enrolment process should identify factors that influence current health status such as GP care quality, Practice IT and decision support software and access to allied health services. It should also assess whether the factors influencing the patient’s current outcomes are likely to change under DCCI, including the care currently provided by the GP. Hence, the patient consent process should be preceded by a peer audit of the quality of care provided to each patient.

Third option for care:

GPs and patients would benefit from additional care options for patients whose outcomes are currently suboptimal but unlikely to improve under DCCI. Such care options include: Indigenous Health services; migrant health services; and specialist diabetes clinics, predominately those in tertiary centres.

Reporting on both enrolled and unenrolled patients:

Service use and outcomes such as hospital admissions are expected to be monitored for enrolled patients. Additionally outcomes for diabetes patients from a given practice who do, and do not, enrol, and from participating and non-participating practices should be reported. This approach will minimise the risk that the benefits of DCC are overestimated and the unintended consequences for unenrolled patients are unobserved.

Improved efficiency and financing of models of allied health service delivery:

Increased demand for allied health services, a constrained resource, is an inevitable result of a policy responding to poor access to such services. Improved referral processes can improve access but improved service models are necessary to improve the efficiency with which constrained resources are able to supply increased demand.

Key findings

POLICY SIMULATION

- > The validation of the method was in its capacity to identify structural uncertainty and risk management strategies not considered in the current policy narrative and policy design. Other researchers could have identified different sources of structural uncertainty.
- > Researchers from an EBM paradigm found policy simulation a difficult technique and tended, initially, to be very skeptical of its value. A typical response when a structural parameter is introduced to such a researcher is: “But there is no evidence of its value so how can we assume it has a value of x%?”
- > A key distinction for EBM researchers was that between:
 - o assuming a parameter has a value of x%; and
 - o using this value to test whether it matters if a parameter has a value apart from that assumed implicitly (typically 0% or 100%).

RISK MANAGEMENT FOR DCC INITIATIVE AND PILOT

- > Any THC developed to improve care for patients should include consideration of the critical elements identified in this research. A policy simulation developed with policy makers or other researchers could identify additional sources of structural uncertainty.
- > Data that is in the private domain of Medical Practitioners and DoHA (Medicare) could be used to inform the possible value of “known unknowns” and guide risk management strategies, without compromising the privacy of individual GPs or patients.
- > The policy narrative in situations where patients are required to provide informed consent in order to have care outside a universal primary care scheme should be realistic rather than optimistic about the potential benefits of enrolment. Not all patients with a given condition have a capacity to benefit from a THC style initiative.

The research reported in this paper is a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Australian Government Department of Health and Ageing under the Primary Health Care Research, Evaluation and Development Strategy. The information and opinions contained in it do not necessarily reflect the views or policies of the Australian Government Department of Health and Ageing.